Complete Summary

GUIDELINE TITLE

Chronic pelvic pain. In: Guidelines on chronic pelvic pain.

BIBLIOGRAPHIC SOURCE(S)

Chronic pelvic pain. In: Fall M, Baranowski AP, Elneil S, Engeler D, Hughes J, Messelink EJ, Oberpenning F, Williams AC. Guidelines on chronic pelvic pain. Arnhem, The Netherlands: European Association of Urology (EAU); 2008 Mar. p. 8-62. [365 references]

GUIDELINE STATUS

This is the current release of the guideline.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- July 08, 2008 – Fluoroquinolones (ciprofloxacin, norfloxacin, ofloxacin, levofloxacin, moxifloxacin, gemifloxacin): A BOXED WARNING and Medication Guide are to be added to the prescribing information to strengthen existing warnings about the increased risk of developing tendinitis and tendon rupture in patients taking fluoroquinolones for systemic use.

COMPLETE SUMMARY CONTENT

** REGULATORY ALERT **
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SCOPE

DISEASE/CONDITION(S)

Chronic pelvic pain (chronic urogenital pain) syndromes:

- Bladder pain syndrome/interstitial cystitis
- Urethral pain syndrome
- Penile pain syndrome
- Prostate pain syndrome
- Scrotal pain syndrome
- Testicular pain syndrome
- Post-vasectomy pain syndrome
- Epididymal pain syndrome
- Endometriosis-associated pain syndrome
- Vaginal pain syndrome
- Vulvar pain syndrome
- Generalized vulvar pain syndrome (formerly dysaesthetic vulvodynia)
- Localized vulvar pain syndrome
- Vestibular pain syndrome (formerly vulval vestibulitis)
- Clitoral pain syndrome
- Anorectal pain
- Pudendal pain syndrome
- Perineal pain syndrome
- Pelvic floor muscle pain syndrome

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Obstetrics and Gynecology
Surgery
Urology

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

- To help urologists in the clinical decisions they make every day
- To provide access to the best contemporaneous consensus view on the most appropriate management currently available

TARGET POPULATION

Patients with chronic pelvic pain

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis/Evaluation

General Considerations

1. Classification of chronic pelvic pain syndromes
2. Patient history
3. Symptom scores
4. Physical examination
5. Organ-specific tests (see below)
6. Palpation of pelvic floor muscles
7. Formation of a pain team

Chronic Prostate Pain/Chronic Prostatitis Associated with Chronic Pelvic Pain Syndrome (CP/CPSS)

1. Digital rectal examination (DRE)
2. Prostate-specific antigen (PSA) if age >50
3. Uroflow
4. Ultrasound with post-void residual urine (PVR)
5. Pre- and post massage test (PPMT)
6. Urodynamics and cystoscopy (if uroflow abnormal)

Bladder Pain Syndrome/Interstitial Cystitis (BPS/IC)

1. Urinalysis
2. Cystoscopy with bladder distention and biopsy
3. Potassium chloride bladder permeability test
4. Biological markers

Scrotal Pain

1. Scrotal palpation
2. DRE
3. Ultrasound, magnetic resonance imaging, computed tomography

Urethral Pain

1. Detailed micturition history
2. Urethral palpation
3. Urine culture and microscopy
4. Uroflow
5. Urethro-cystoscopy
6. Urodynamic studies, if indicated

Treatment/Management

General Considerations

1. Treatment of recognized pain syndromes according to published guidelines
2. Referral to a pain team

CP/CPPS

1. Antibiotics
2. Alpha-blocker
3. Phytotherapy
4. Non-steroidal anti-inflammatory drugs (NSAIDS)
5. Muscle relaxants
6. Thermotherapy
7. Electromagnetic therapy (only within a clinical trial)
8. Corticosteroids (not recommended)
9. 5-alpha-eductase inhibitors
10. Supportive therapy (e.g., biofeedback, relaxation therapy, diet changes, exercise changes, acupuncture, massage therapy, chiropractic therapy, meditation)
11. Surgery (not recommended unless additional indications are present)

BPS/IC

1. Analgesics
2. Corticosteroids (not recommended long-term)
3. Hydroxyzine, amitriptyline, or pentosan polysulphate sodium (PSS) (standard treatment)
4. Antibiotics
5. Cyclosporin A
6. Prostaglandins
7. Other drugs with limited data
8. Intravesical instillation (anaesthetic, PPS, heparin, hyaluronic acid, chondroitin sulphate, dimethyl sulphoxide [DMSO], vanilloids)
9. Intravesical bacillus Calmette-Guérin or clorpactin (not recommended)
10. Bladder distension
11. Electromotive drug administration
12. Transurethral resection (coagulation and LASER) (single-diagnosis use only)
13. Nerve blockade/epidural pain pumps
14. Physical and psychotherapies
15. Experimental therapies (botulinum toxin, sacral neuromodulation)
16. Surgery

Scrotal Pain

1. Antibiotics
2. Physiotherapy (pelvic floor muscle therapy)
3. Surgery

Urethral Pain

1. Antibiotics
2. Alpha-blocker
3. NSAIDs
4. Acupuncture

5. Laser therapy
6. Psychological support

MAJOR OUTCOMES CONSIDERED

- Specificity and sensitivity of diagnostic tests
- Change in symptom scores
- Change in pain scores
- Side effects of therapy
- Quality of life

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

A structured literature search was performed, limited to randomized controlled trials and meta-analyses, covering at least the past three years, or up until the date of the latest text update if this exceeds the three-year period. Other excellent sources to include were other high-level evidence, Cochrane review and available high-quality guidelines produced by other expert groups or organizations. If there were no high-level data available, the only option was to include lower-level data. The choice of literature was guided by the expertise and knowledge of the Guidelines Working Group.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

1a Evidence obtained from meta-analysis of randomized trials

1b Evidence obtained from at least one randomized trial

2a Evidence obtained from one well-designed controlled study without randomization

2b Evidence obtained from at least one other type of well-designed quasi-experimental study

3 Evidence obtained from well-designed non-experimental studies, such as comparative studies, correlation studies and case reports

4 Evidence obtained from expert committee reports or opinions or clinical experience of respected authorities

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

- The first step in the European Association of Urology (EAU) guidelines procedure is to define the main topic.
- The second step is to establish a working group. The working groups comprise about 4 to 8 members, from several countries. Most of the working group members are academic urologists with a special interest in the topic. Specialists from other medical fields (pain medicine, psychology, radiotherapy, oncology, gynaecology, anaesthesiology, etc.) are included as full members of the working groups as needed. In general, general practitioners or patient representatives are not part of the working groups. Each member is appointed for a four-year period, renewable once. A chairman leads each group.
- The third step is to collect and evaluate the underlying evidence from the published literature.
- The fourth step is to structure and present the information. All main recommendations are summarized in boxes and the strength of the recommendation is clearly marked in three grades (A-C), depending on the evidence source upon which the recommendation is based. Every possible effort is made to make the linkage between the level of evidence and grade of recommendation as transparent as possible.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grades of Recommendation

A. Based on clinical studies of good quality and consistency addressing the specific recommendations and including at least one randomized trial

B. Based on well-conducted clinical studies, but without randomized clinical studies
C. Made despite the absence of directly applicable clinical studies of good quality

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The Appraisal of Guidelines for Research and Evaluation (AGREE) instrument was used to analyse and assess a range of specific attributes contributing to the validity of a specific clinical guideline. The AGREE instrument, to be used by two to four appraisers, was developed by the AGREE collaboration (www.agreecollaboration.org) using referenced sources for the evaluation of specific guidelines. (See the "Availability of Companion Documents" field for further methodology information).

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Definitions for the level of evidence (**1-4**) and grade of recommendation (**A-C**) are provided at the end of the "Major Recommendations."

Background

Introduction to Chronic Urogenital Pain Syndromes

Basic investigations must be undertaken to rule out 'well-defined' pathologies. If the results are negative, a 'well-defined' pathology is unlikely. Any further investigations should be done only for specific indications, e.g., for subdivision of a pain syndrome.

The definitions for chronic urogenital pain syndromes are based on the recommendation for terminology laid down by the International Continence Society (ICS) and follow the axial structure of the International Association for the Study of Pain (IASP) classification (see Tables 1 and 2 in the original guideline document).

An Algorithm for Chronic Pelvic Pain Diagnosis and Treatment

The algorithm for diagnosing and treating chronic pelvic pain (CPP) (see Figure 1 in the original guideline document) has been written to guide a physician through the process from diagnosis to management. A physician should follow steps 1 to 6

(see Table below), while referring to the correct column in the algorithm. Further guidance on which diagnostic tools should be used in specific pain locations is provided in different chapters of the original guideline document.

Table. Step-by-step Guidance on Using the Algorithm* for Diagnosis and Treatment of CPP

Step	Action
1	Start by considering the organ system where the symptoms appear to be primarily perceived
2	'Well-defined' conditions, such as cystitis, should be diagnosed and treated according to national or international guidelines
3	When treatment has no effect on the pain, additional tests (e.g., cystoscopy or ultrasound) should be performed
4	When these tests reveal any pathology, this should be treated appropriately
5	If treatment has no effect, the patient should be referred to a pain team
6	If no well-defined condition is present or when no pathology is found by additional tests, the patient should also be referred to a pain team

The only aspect of diagnosis that is specific for CPP is where the pain is localized. However, because pain is perceived in structures related to the pelvis, this has led to many organ-specific, but often not well-defined, local disease syndromes.

Because CPP is pain perceived in structures related to the pelvis, it is necessary to approach diagnosis of a patient with CPP as a chronic pain patient. Confining the diagnosis to a specific organ may overlook multisystem functional abnormalities requiring individual treatment and general aspects of pain in planning investigation and treatment.

For the above reasons, the guideline authors advocate early involvement of a multidisciplinary pain team. In practice, this should mean that well-known diseases, e.g., 'true' cystitis and endometriosis, will be diagnosed and treated early. If treating such conditions does not reduce symptoms, or such well-defined conditions are not found, then further investigation may be necessary, depending on where the pain is localized.

It should be noted, however, that over-investigation may be as harmful as not performing appropriate investigations. The European Association of Urology (EAU) algorithms introduce the concept of the 'minimum investigations' required to exclude a well-defined condition.

Chronic Prostate Pain/Chronic Prostatitis Associated with Chronic Pelvic Pain Syndrome (CP/CPPS)

Definition

Chronic prostatitis associated with chronic pelvic pain syndrome (CP/CPPS) is discomfort or pain in the pelvic region over a minimum of 3 months, with sterile specimen cultures and either significant, or insignificant, white blood cell counts in prostate-specific specimens (i.e., semen, expressed prostatic secretions and urine collected after prostate massage). The disease is referred to as 'prostate pain syndrome (CP/CPPS)' throughout the rest of this chapter.

Diagnosis

Despite its name, prostate pain syndrome (CP/CPPS) is a symptomatic diagnosis, which is diagnosed from a 3-month history of genitourinary pain and an absence of other lower urinary tract pathologies (see above). Determination of the severity of disease, its progression and treatment response can be assessed only by means of a validated symptom-scoring instrument. Quality of life should also be measured because it can be as poor as in acute myocardial infarction, unstable angina pectoris or Crohn's disease. Reliable, valid indexes of symptoms and quality of life are the National Institutes of Health (NIH) Prostatitis Symptom Index (NIH-CPSI) and the International Prostate Symptom Score (I-PSS). These subjective outcome measures are recommended for the basic evaluation and therapeutic monitoring of patients in urological practice and have been translated and validated for many European languages.

In prostate pain syndrome (CP/CPPS), urodynamic studies demonstrate decreased urinary flow rates, incomplete relaxation of the bladder neck and prostatic urethra, as well as abnormally high urethral closure pressure at rest. The external urethral sphincter is normal during urination.

Laboratory diagnosis has been classically based on the four-glass test for bacterial localization ('gold standard'). Besides a sterile pre-massage urine (voided bladder urine-2 [VB2], CP/CPPS shows less than 10,000 colony-forming units of uropathogenic bacteria in expressed prostatic secretions (EPS) and insignificant numbers of leucocytes or bacterial growth in ejaculate. However, this test is too complex for use by practising urologists. Diagnostic efficiency may be enhanced cost-effectively by a simple screening procedure, i.e., the two-glass test or pre-post-massage test (PPMT). In an extensive analysis of both tests, PPMT was able to indicate the correct diagnosis in more than 96% of patients.

A general algorithm for diagnosis and treatment of chronic prostatic pain is shown in Figure 2 of the original guideline document.

Treatment

Because of the unknown cause of prostate pain syndrome (CP/CPPS), many therapies used are based on anecdote. Most patients require multimodal treatment aimed at the main symptoms and taking comorbidities into account. In the past few years, results from randomized controlled trials (RCTs) have led to

advances in standard and novel treatment options. Graded recommendations are given in the table below.

Table. Treatment of Prostate Pain Syndrome (CP/CPPS)

	Level of Evidence	Grade of Recommendation	Comment
• Alpha-blockers	**1a**	**A**	Effect on total NIH-CPSI
• Muscle relaxants	**3**	**C**	Only very limited data
• Antimicrobial therapy	**3**	**B**	Quinolones If previously untreated (naïve) only, reassess after 2-3 weeks. Duration 4-6 weeks
• Opioids	**3**	**C**	As part of multimodal therapy for treatment-refractory pain in collaboration with pain clinics
• Non-steroidal anti-inflammatory drugs	**1b**	**B**	Long-term side effects have inflammatory drugs to be considered
• Steroids • Immunosuppressive agents	**3**	**Not recommended**	Not outside clinical trials
• 5-alpha-reductase inhibitors	**1b**	**B**	If benign prostatic hyperplasia is present
• Phytotherapy	**1b-3**	**B**	
• Biofeedback, relaxation exercise • Lifestyle changes • Massage therapy • Chiropractor therapy • Acupuncture	**2a-3**	**B**	As supportive, second-line therapies

	Level of Evidence	Grade of Recommendation	Comment
• Meditation			
• Electromagnetic therapy	**1b**	**C**	Not outside clinical trials
• Transrectal hyperthermia • Transurethral thermotherapy	**3**	**C**	
• Transurethral incision of the bladder neck • Transurethral resection of the prostate • Radical prostatectomy	**3**	**Not recommended in general**	Specific additional indication required

Bladder Pain Syndrome/Interstitial Cystitis (BPS/IC)

Introduction

It is very important to realise that IC is a heterogeneous spectrum of disorders, which are still poorly defined, and that inflammation is an important feature in only a subset of patients. To embrace all patients suffering from bladder pain, the terms painful bladder syndrome (PBS) or bladder pain syndrome (BPS) have been suggested as more accurate terminology. This terminology assumes that IC represents a special type of chronic inflammation of the bladder, while PBS or BPS refers to pain in the bladder region. The term bladder pain syndrome of BPS will be used in these guidelines.

Diagnosis

The diagnosis of BPS is made using symptoms, examination, urine analysis, cystoscopy with hydrodistension and biopsy (see Figure 3 in the original guideline document). Patients present with characteristic pain and urinary frequency, which is sometimes extreme and always includes nocturia.

The character of the pain is the key symptom of the disease:

- Pain is related to the degree of bladder filling, typically increasing with increasing bladder content.
- It is located suprapubically, sometimes radiating to the groins, vagina, rectum or sacrum.
- Pain is relieved by voiding but soon returns.

The differences between the two IC subtypes include clinical presentation and age distribution, and they may be discriminated non-invasively. The two subtypes

respond differently to treatment and express different histopathological, immunological and neurobiological features.

Classic IC is a destructive inflammation with some patients eventually developing a small-capacity fibrotic bladder or upper urinary tract outflow obstruction. There is no such progression in non-ulcer disease. Endoscopically, classic IC displays reddened mucosal areas often associated with small vessels radiating towards a central scar, sometimes covered by a small clot or fibrin deposit. The scar ruptures with increasing bladder distension, producing a characteristic waterfall-type of bleeding. There is a strong association between classic IC and reduced bladder capacity under anaesthesia.

Medical Treatment

A summary of the treatment options for BPS/IC, including a rating of the level of evidence and grade of recommendation is given in the tables 'Medical Treatment of BPS/IC' and 'Intravesical, Interventional, Alternative and Surgical Treatment of BPS/IC' below. Figure 3 in the original guideline document provides a flowchart for the diagnosis and therapy of BPS/IC based on the information discussed above.

Table. Medical Treatment of BPS/IC

	Level of Evidence	Grade of Recommendation	Comment
Analgesics	**2b**	**C**	Indications limited to cases awaiting further treatment
Corticosteroids	**3**	**C**	Corticosteroids not recommended as long-term treatment
Hydroxyzine	**1b**	**A**	Standard treatment, even though limited efficacy shown in randomized controlled trial (RCT)
Cimetidine	**1b**	**B**	Insufficient data
Amitriptyline	**1b**	**A**	Standard treatment
Sodium pentosan polysulphate sodium (PPS)	**1a**	**A**	Standard treatment Data contradictory
Antibiotics	**1b**	**A**	Limited role in the treatment of interstitial cystitis (IC)
Prostaglandins	**3**	**C**	Insufficient data on IC, adverse effects
L-arginine	**1b**	**C**	Effect in IC uncertain

	Level of Evidence	Grade of Recommendation	Comment
Cyclosporin A	**1b**	**A**	RCT: superior to PPS but more adverse effects
Duloxetine	**2b**	**C**	No effect, tolerability poor
Oxybutynin/tolterodine	**3**	**C**	Limited indication in IC
Gabapentin	**3**	**C**	Preliminary data so far
Suplatast tosilate	**3**	**C**	Preliminary data so far
Quercetin	**3**	**C**	Preliminary data so far

Table. Intravesical, Interventional, Alternative and Surgical Treatment of BPS/IC

	Level of Evidence	Grade of Recommendation	Comment
Intravesical anaesthesia	**3**	**C**	
Intravesical pentosan polysulphate sodium (PPS)	**1b**	**A**	
Intravesical heparin	**3**	**C**	
Intravesical hyaluronic acid	**2b**	**B**	
Intravesical chondroitin sulphate	**2b**	**B**	
Intravesical dimethyl sulphoxide (DMSO)	**1b**	**A**	
Intravesical bacillus Calmette-Guérin	**1b**	**Not recommended**	
Intravesical clorpactin	**3**	**Not recommended**	Obsolete
Intravesical vanilloids	**1b**	**C**	Data contradictory
Bladder distension	**3**	**C**	
Electromotive drug administration	**3**	**B**	
Transurethral resection (coagulation and LASER)	**NA**	**A/B**	Hunner's lesions only
Nerve blockade/epidural pain pumps	**3**	**C**	For crisis intervention; affects pain only

	Level of Evidence	Grade of Recommendation	Comment
Sacral neuromodulation	**3**	**B**	Not recommended beyond clinical trials
Bladder training	**3**	**B**	Patients with little pain
Manual and physical therapy	**3**	**B**	
Diet	**3**	**C**	
Acupuncture	**3**	**C**	Data contradictory
Hypnosis		**No data**	
Psychological therapy	**3**	**B**	
Surgical treatment	**NA**	**A**	Largely varying data ultima ratio, experienced surgeons

NA = type of evidence not applicable, since RCTs are unethical in such surgical procedures.

Scrotal Pain

An algorithm for diagnosing and managing scrotal pain is provided in Figure 4 of the original guideline document.

A physical examination should always be done in patients with scrotal pain. Gentle palpation of each component of the scrotum is performed to search for masses and for painful spots. A digital rectal examination (DRE) is done to look for prostate abnormalities and examine the pelvic floor muscles. Scrotal ultrasound has limited value in finding the cause of the pain.

If physical examination is normal, ultrasound is sometimes performed to reassure the patient that there is no tumour in the testis. Ultrasound can be used to diagnose hydroceles, spermatoceles, cysts and varicoceles. The urine should be analysed. Magnetic resonance imaging and computed tomography scans may be used to help with assessment.

Recommendations for the treatment of scrotal pain syndrome are listed in the table below.

Table. Treatment of Scrotal Pain Syndrome

	Level of Evidence	Grade of Recommendation	Comment
Orchiectomy	**1a**	**A**	In case of intratesticular tumour
Excision	**3**	**B**	Hydrocele or varicocele

	Level of Evidence	Grade of Recommendation	Comment
Antibiotics	**3**	**C**	For up to 3 months
Surgical intervention	**3**	**C**	Epididymectomy, denervation spermatic cord Vasovasostomy
Pelvic floor muscle therapy	**1b**	**A**	Including trigger point treatment

Urethral Pain Syndrome

Positive diagnostic signs are urethral tenderness or pain on palpation and a slightly inflamed urethral mucosa found during endoscopy.

In clinical practice, the diagnosis of urethral pain syndrome is commonly given to patients who present with the symptoms of dysuria (with or without frequency, nocturia, urgency and urge incontinence) in the absence of evidence of urinary infection. The 'absence of urinary infection' cause diagnostic problems as the methods typically used to identify urinary infection are extremely insensitive. Dysuria is pain or discomfort experienced in association with micturition. The classical symptom of a burning sensation in the urethra during voiding caused by infection is well known. The external dysuria experienced by women with vaginitis when urine passes over the labia is less appreciated.

Biochemical testing and microbiological culture of urine is important in assessing lower urinary tract symptoms and has been reviewed in some detail in the elderly.

There is confusion about the concept of significant bacteriuria. This may be accepted as 10^5 colony-forming units (CFU) of a single species in asymptomatic women. However, it may be as low as 10^2 CFU of a single species of a known urinary pathogen in symptomatic women. Many automated culture systems have a sensitivity of 10^4 CFU, while urinary leucocyte esterase and nitrite tests are correlated only with cultures as high as 10^5 CFU. In addition, many laboratory culture systems detect only just over 50% of infections in midstream urine specimens from genuinely infected patients.

Although rarely included, proper manual urine microscopy using a haemocytometer should be part of a definitive work-up. Nowadays, most laboratories screen urine in wells using inverted microscopes or rely on robotic detection of pyuria, which are both insensitive methods. This is regrettable because studies have shown that significant pyuria is a nearly universal indicator of urinary tract infection, although it is not specific for differentiating cystitis from urethritis, particularly urethritis due to *Chlamydia trachomatis*. In relation to the latter, dysuria also merits the microscopic examination of a urethral smear after it has been Gram stained. If present, a purulent urethral exudate will be obvious, although a causative micro-organism will be identified in less than 50% of cases.

Urethral trauma arising from intercourse may cause pain and dysuria. Women with pelvic floor dysfunction sometimes describe similar symptoms, as do post-menopausal women, in whom trauma is associated with oestrogen deficiency, loss of lubrication and vaginal dryness.

Unless a thorough assessment is carried out, bearing in mind the comments described above, the diagnosis of urethral pain syndrome does not seem credible.

Treatment

There is no consensus on treatment. Management may require a multidisciplinary approach. Various modalities including antibiotics, alpha-blockers, acupuncture and laser therapy have been proved successful. Psychological support is important. An algorithm for diagnosing and managing urethral pain syndrome is given in Figure 5 of the original guideline document.

Definitions

Levels of Evidence

1a Evidence obtained from meta-analysis of randomized trials

1b Evidence obtained from at least one randomized trial

2a Evidence obtained from one well-designed controlled study without randomization

2b Evidence obtained from at least one other type of well-designed quasi-experimental study

3 Evidence obtained from well-designed non-experimental studies, such as comparative studies, correlation studies and case reports

4 Evidence obtained from expert committee reports or opinions or clinical experience of respected authorities

Grades of Recommendations

A. Based on clinical studies of good quality and consistency addressing the specific recommendations and including at least one randomized trial
B. Based on well-conducted clinical studies, but without randomized clinical studies
C. Made despite the absence of directly applicable clinical studies of good quality

CLINICAL ALGORITHM(S)

The original guideline document contains the following clinical algorithms:

- An algorithm for diagnosing and managing chronic pelvic pain (CPP)
- General diagnostic and treatment algorithm for chronic prostate pain

- Flowchart for the diagnosis and therapy of bladder pain syndrome/interstitial cystitis
- An algorithm for diagnosing and managing scrotal pain
- An algorithm for diagnosing and managing urethral pain syndrome

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for selected treatment recommendations (see the "Major Recommendations" field).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Accurate diagnosis and evaluation of chronic pelvic pain syndromes to determine the cause of pain
- Appropriate treatment and management of chronic pelvic pain syndromes
- Relief of suffering caused by chronic pelvic pain syndromes

POTENTIAL HARMS

- Side effects of medical treatments
- Associated risks of surgical treatment

CONTRAINDICATIONS

CONTRAINDICATIONS

- Dimethyl sulphoxide (DMSO) is contraindicated during urinary tract infections or shortly after bladder biopsy.
- The authors currently consider bladder pain syndrome/interstitial cystitis (BPS/IC) to be a contraindication for enterocystoplasty.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The European Association of Urology (EAU) believes that producing validated best practice in the field of urology is a very powerful and efficient tool in improving patient care. It is, however, the expertise of the clinician which should determine the needs of their patients. Individual patients may require individualized approaches which take into account all circumstances and treatment decisions often have to be made on a case-by-case basis.
- There are some very clear limitations on the use of the EAU Guidelines. These guidelines are specifically aimed at helping the practising urologist and will thus be of limited use to other health care providers or third party payers. These are limitations which we have accepted, given that the aim is to cover

all of Europe and that such non-clinical questions are best covered locally. Another limitation is that the texts have no medico-legal status, nor are they intended to be used as such.

- The purpose of this text is not to be proscriptive in the way a clinician should treat a patient but rather to provide access to the best contemporaneous consensus view on the most appropriate management currently available. EAU guidelines are not meant to be legal documents but are produced with the ultimate aim to help urologists with their day-to-day practice.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The European Association of Urology (EAU) Guidelines long version (containing all 19 guidelines) is reprinted annually in one book. Each text is dated. This means that if the latest edition of the book is read, one will know that this is the most updated version available. The same text is also made available on a CD (with hyperlinks to PubMed for most references) and posted on the EAU websites Uroweb and Urosource (www.uroweb.org/professional-resources/guidelines/ & http://www.urosource.com/diseases/).

Condensed pocket versions, containing mainly flow-charts and summaries, are also printed annually. All of these publications are distributed free of charge to all (more than 10,000) members of the Association. Abridged versions of the guidelines are published in European Urology as original papers. Furthermore, many important websites list links to the relevant EAU guidelines sections on the association websites and all, or individual, guidelines have been translated to some 15 languages.

IMPLEMENTATION TOOLS

Clinical Algorithm
Pocket Guide/Reference Cards

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Chronic pelvic pain. In: Fall M, Baranowski AP, Elneil S, Engeler D, Hughes J, Messelink EJ, Oberpenning F, Williams AC. Guidelines on chronic pelvic pain. Arnhem, The Netherlands: European Association of Urology (EAU); 2008 Mar. p. 8-62. [365 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2008 Mar

GUIDELINE DEVELOPER(S)

European Association of Urology - Medical Specialty Society

SOURCE(S) OF FUNDING

European Association of Urology

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

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Electronic copies: Available in Portable Document Format (PDF) from the European Association of Urology Web site.

Print copies: Available from the European Association of Urology, PO Box 30016, NL-6803, AA ARNHEM, The Netherlands.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- EAU guidelines office template. Arnhem, The Netherlands: European Association of Urology (EAU); 2007. 4 p.
- The European Association of Urology (EAU) guidelines methodology: a critical evaluation. Arnhem, The Netherlands: European Association of Urology (EAU); 18 p.

The following is also available:

- Guidelines on chronic pelvic pain. 2005, Ultra short pocket guidelines. Arnhem, The Netherlands: European Association of Urology (EAU); 2008 Mar. 18 p.

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